SUCCESSFUL PARTNERSHIPS: THE PROFIT PROJECT IN ZIMBABWE

THE CHALLENGE

Implement a comprehensive project to address the challenge of increasing the role of the private sector in family planning.

The PROFIT Project, although a Washington, DC-based centrally funded United States Agency for International Development (USAID) Project, worked in Zimbabwe through a USAID Mission buy-in. It was given two years to implement a comprehensive project to address the challenge of increasing the role of the private sector in family planning. The Project included complementary initiatives. Some initiatives aimed at increasing the number of qualified providers. These involved training private doctors, nurse midwives, and pharmacists to offer family planning services as well as improving the quality and expanding the method mix of family planning services at work-sites; Other activities were designed to increase the demand for such services by motivating clients, who could afford it, to use the private sector for their family planning needs and encouraging clients of the two largest medical aid societies (health insurance) to claim benefits for those services.

What was the key to PROFIT's success? The Project involved the beneficiaries in planning and implementing the project activities.

To what extent was the Project a success? "Remarkable" said many of the members of the PROFIT Project's Coordinating Committee, the beneficiaries, including private pharmacists, doctors, nurse-midwives, occupational health nurses from companies, staff from pharmaceutical companies as well as from the two largest medical aid societies.

PHARMACY INITIATIVE

"The PROFIT Project far exceeded my expectations" said Andrew Vaughn, President of the Retail Pharmacists' Association, a member of the PROFIT Project Coordinating Committee, and the main coordinator of the Pharmacy Initiative. "In a short period of time (i.e., a five-month period), we have succeeded in training 92 pharmacists' from 87 pharmacies and increased their confidence in educating, prescribing, and initiating oral contraceptives.

"The PROFIT Project far exceeded my expectations", said Andrew Vaughn, President of the Retail Pharmacists' Association, member of the PROFIT Project Coordinating Committee, and the main liaison between the pharmacists and PROFIT.

Moreover, this Project has enabled some of the pharmacists to explore the possibility of delivering improved quality pharmacy care by incorporating model elements into their pharmacies (i.e., a quiet room where trained staff can provide education and counselling to clients as well as provide educational materials). Mr. Vaughn, who suggested the concept of "model pharmacies" during the PROFIT Planning Meeting in January 1996, feels that family planning is in fact an ideal entree into quality pharmacy care. "The success of the PROFIT Project has been the whole expansion of pharmacists' family planning knowledge; it is about changing pharmacists' attitudes, broadening their horizons by getting them out of their dispensaries so that patients don't think that pharmacists' are glorified shopkeepers. It's about customers feeling that they are getting value for their money and about the quality pharmacy care that pharmacies can now offer. People can come in and get really good advice about the methods, and talk about their problems. The question about product sales is really a price question. Unfortunately, the cheapest alternative of family planning pills on the private sector market is Z$35 (US$=3.50) per month. This compares to Z$2 (US$.20)per month in the public sector.

In addition, the Project "hasn't just been a Harare-based or Bulawayo-based program", but instead has included pharmacists from all over the country. It has enabled all those who have been involved to look at the different patterns and discuss each pharmacist's specific problems. "For instance in smaller centers,

there may be fewer family planning clinics, which means that the pharmacies may have more family planning clients than a pharmacy in the middle of Harare. This means there are different expectations", continued Mr. Vaughn.

DOCTORS' INITIATIVE

The planners and trainers of the Project activities were well-respected members of their professional organizations. As the PROFIT Project Director so succinctly put it, "No one wants to be left out when Professor Kasule (master trainer) is Chairing."

The doctors and others involved in the Project felt that it had accomplished what no other had done. It had gotten private, general practitioners out of their surgeries and into family planning training workshops. In fact, the enthusiasm was so great that the applications far exceeded the number of spaces available at the training workshops. Those who could not be accommodated in the training workshops, especially the practical ones, were extremely disappointed. "I get calls every day from doctors who want to be trained in family planning...", said Dr. Alex Zinanga, Executive Director of the ZNFPC, "... this overwhelming response has been a surprise...".

Those who were able to participate in the training felt honored and excited to be a part of the Project. The participants felt that the training gave them the much needed boost in confidence to provide family planning services. What was the key to PROFIT's success? The PROFIT Project asked doctors what their training needs were and what type of scheduling would allow them to attend training workshops. Then the training workshops were organized to meet their stated needs and held at times that minimized the amount of time participants had to take away from their practices to attend. Also, PROFIT recruited trainers who were very well-respected members of the medical fraternity. As the PROFIT Project Director so succinctly put it, "No one wants to be left out when Professor Kasule is Chairing!" (Professor Kasule is and has been an instructor for many years at the Department of Obstetrics and Gynecology at the University of Zimbabwe. In fact, he has taught a lot of the doctors in Zimbabwe.) Another reason for the overwhelming response said PROFIT trainers, Drs. Chipato (Department of Obstetrics and Gynecology at the University of Zimbabwe), Parirenyatwa (President, College of Primary Care Physicians), and Mamsa (private doctor who previously has worked as a medical officer in the Ministry of Health and the Zimbabwe National Family Planning Council) was that the training was developed by local professionals who understood the doctors' needs and appreciated the challenges they faced in their practices. The enthusiasm and professionalism of the PROFIT Project staff who did an exceptional job of coordinating the workshop logistics was also cited as a contributing factor to the Project's success by all those who were interviewed.

"The PROFIT Project checked why others failed when it came to training doctors and came up with a different approach." Said Dr. Mamsa, a member of the Doctors Working Group and one of the trainers. "Nothing was imposed on the doctors." From the beginning, PROFIT sought to involve influential members of the medical fraternity in the design and implementation of the Doctors? Initiative. "When we invited them (the doctors), we didn't say that we had a plan. We invited them and said, "Here are some funds" we would like to work with you but we are not sure what to do or where to start." So we didn't have set intentions and it was clear that we weren't going to dictate." Dr. Parirenyatwa and Professor Kasule were very appreciative of this because they had expected the usual. That is, people to come in with their own plans and say, "We want to do this and that." They liked this approach because it became their Project, and it was like we were working for them." The common things we would hear during the planning process was, "This is our program and we need to show that in Zimbabwe we can do it independently. We don't need an expatriate to come in and show us what to do." " This Project was everybody's Project. Everybody participated." said Lois Lunga, Project Director.

The members of the medical fraternity, who were identified to lead this Initiative, formed a working group and designed a training program that was based on a needs assessment they conducted with the membership of the Zimbabwe Medical Association (ZIMA) and the College of Primary Health Care Physicians. As a result of their findings, they outlined two courses: a theory course on family planning for two days and a three day practical course on NORPLANT and intrauterine device (IUD) insertion and removal. Participants for the practical course were selected after they had participated in the theory one. The selection process of both courses made sure that the doctors came from all over the country so that there would be national coverage. In fact, doctors in areas where ZNFPC did not have representation, such as Beitbridge, were given priority.

Efforts were made to ensure that all training materials, including the videos, were relevant to Zimbabwe. "In fact, Professor Kasule believes that in Zimbabwe we have our own way of doing NORPLANT, which is related to our economic status", added Lois Lunga. The training ensured that each participant in the practical course was exposed to all four trainers (Professor Kasule, Drs. Chipato, Parirenyatwa, and Mamsa) and to all three sites, which were Parirenyatwa Hospital, Chitungwiza Hospital, and Spilhaus clinic at the ZNFPC headquarters, to give them a more rounded experience.

In addition, the training was designed to sharpen the trainer's own skills because the trainers took on assignments that continuously challenged them. For example, Dr. Parirenyatwa said that he chose to make a presentation on *Family Planning in General Practice*, which entailed considerable research into the local situation. It also meant being creative enough to come up with concrete strategies to overcome constraints.

Moreover, the PROFIT training did not use guest speakers who made presentations and left. The trainers were at the training workshops throughout and participated in all discussions. "This training, which did not involve outsiders, is sustainable as similar programs can continue to draw on the same pool of resources," emphasized Dr. Parirenyatwa.

An early decision was made not to train doctors unless they had sufficient clients and equipment to allow them to begin using their new skills soon after their training. When interviews with potential trainees and visits to their offices showed that relatively few had the necessary equipment and they were not inclined to buy equipment because they weren't confident that they could recover the costs for it, PROFIT decided to provide equipment to its trainees. This proved expensive because they would need sterilizers, trocars, IUD and NORPLANT starter kits in addition to what was needed for the actual training itself. Thus, the number of doctors recruited to attend the practical was reduced from 40 to 28, and they were asked to pay their own transportation costs.

The one criticism of the doctors' initiative was related to the reduced number of doctors trained. They should have asked the doctors to actually pay for the training in addition to asking them to cover their transportation costs. "After all," said one public sector doctor, "this Project is about fostering sustainability, so why are we paying for doctors who are doing well..?" However, while supportive of the sustainability argument, Professor Kasule, the Chairman of the Steering Committee, pointed out that it was unrealistic to expect doctors to invest too much in family planning training and equipment when barriers such as inadequate family planning tariffs and a lack of affordable contraceptive commodities in the private sector have yet to be overcome. However, it was said that to avoid compromises in training targets due to costs, more cost-sharing

alternatives could have been explored.

Despite the problems with family planning tariffs and the lack of inexpensive contraceptive commodities in the private sector, the trainers are convinced that those general practitioners who were trained are providing family planning services. "I am getting a lot more referrals..." said Dr. Chipato. Whereas Dr. Parirenyatwa said that he has had doctors who have called him to tell him that they are looking at their rooms to create space for counselling while one told him that he is on the lookout for a nurse midwife with which to partner.

The four trainers emphasized that it is important to continue systematic follow-up after PROFIT ends. "It's important to evaluate how effectively the doctors are using their training; how the doctors feel now, how they felt during the training, how they felt immediately after the training, and how they feel after some time in their real situation. These are the real indicators ..." said Dr. Mamsa

NURSE-MIDWIVES INITIATIVE

Involving nurse- midwives seemed initially a daunting task as little was known about them. It seemed difficult to achieve the PROFIT Project objective of working with 20 nurse midwives, because it had been difficult to find 20, let alone work with that many. Yet after a year, the PROFIT and SEATS II Projects are working with 48 practicing nurse midwives and eight aspiring ones.

Together, the PROFIT Project and another USAID funded family planning project, the Family Planning Service Expansion and Technical Support II (SEATS II) Project, which has a regional office in Harare, have successfully met the challenge of mobilizing private nurse midwives to provide family planning services. Involving this particular cadre in such an initiative seemed at first a daunting task as very little was known about them. When the baseline survey was conducted in 1996, the Project implementers found it difficult to identify private nurse midwives and were able to identify only six to participate in the research. "They looked on us with suspicion and were not very forthcoming--they thought we were there to police them" said Mrs. Nduna of the Zimbabwe Nurses Association (ZINA). "This was probably because they were confused and uncertain of the legality of what they were doing" said Mary Lee Mantz, the SEATS coordinator on this Initiative. However as a result of the Initiative, many of the nurse practitioners who previously had kept a low profile became more forthcoming. At first it seemed difficult to achieve the PROFIT Project objective of working with 20 nurse midwives because it had been difficult to find 20, let alone work with that many. Yet after a year the PROFIT and SEATS II Projects are working with 48 practicing nurse midwives (representing 61 site service delivery sites) and eight aspiring ones. In addition, instead of being limited to establishing only one "model clinic" as the PROFIT objectives stated, the Initiative has created six such clinics, representing 21 service delivery sites, nationwide.

The Nurse Midwife Initiative began by assessing the actual parameters of their practices in order to assist those midwives in private practice to integrate or expand family planning services. A dissemination workshop was convened to look at the policies that govern a nurse midwife's private practice. The workshop attendees included representatives from the Health Professions Council (HPC), Medical Aid Societies, Medicine Control Authority (MCA) (previously known as the Drug Control Council or DCC), ZNFPC, and ZINA. As a result of this workshop, a policy document, which states the rules and regulations was compiled, but since it has to pass through Parliament, it is not known when it will be in place. A Handbook that outlines the "DOs" and "DON'Ts" for aspiring nurse midwives, however, is expected to be completed by October 1997.

A strategic planning workshop during which a two year plan of action was outlined as well as training courses in family planning (basic and refresher), business management skills, and community mobilization were conducted for the participating nurse midwives.

This Initiative has created an impetus and brought together nurse midwives and policy makers to address the problems and constraints in nurse midwives providing family planning services. The nurses feel less isolated, and those who were on the verge of closing their doors have been able to clarify the parameters of their practices and in fact, have opened more sites. Additional ZINA subgroups, including the Independent Clinics Organisation (ICO), have been formed. As a direct result of the Dissemination Workshop, Public Services Medical Aid Society (PSMAS), one of the leading Medical Aid Societies, has become proactive instead of restrictive and is working with the nurse midwives to come up with family planning tariffs. Despite the headway made in addressing some of the constraints, it will take more than the two year life span (the first one conducted under the PROFIT Project umbrella) of this Initiative to overcome successfully the many policy barriers.

EMPLOYER-BASED INITIATIVE

PROFIT worked closely with the nurses to design the initiative. Their working group developed the selection criteria for companies with which to work and added an important element: peer education programs to motivate men to use and support their partners use of contraceptives.

The Employer-based Initiative was a follow-on to previous USAID Private Sector Projects. But what was unique about the PROFIT Project's approach was that a working group of occupational health nurses was established to design the initiative. The group was organized during the PROFIT- sponsored, first annual meeting of the Zimbabwe Occupational Health Nurses Association (ZOHNA) where more than 70 participants gathered from a variety of industries to share their professional experiences from their work-places in occupational health and safety as well as family planning services. The working group developed the selection criteria for the companies to include in this Initiative and added an element they thought would be important: peer education programs. "In our approach, we worked closely with the nurses themselves...we solicited proposals from the nurses for the peer education programs. In the proposal, the nurse identified the need for the program and designed a program to meet such a need. Once selected to receive a grant, she proceeded to implement the program, thus she felt the program belonged to her and the peer educators. Given this ownership, it is more likely that the activities will continue and therefore be sustainable" said Lois Lunga, Acting Director of the PROFIT Project. This approach also fostered the nurse's taking initiative as the onus was on her to get the requisite permission from management to implement such an employer-based program. The nurses, however, were not left to their own devices as the PROFIT Project offered to provide them with support should they have any problems with management. Out of the 8 companies who received grants for peer education programs, only one admitted to having problems. Yet even this nurse reported she developed solutions by herself and did not request PROFIT's assistance.

Another element of the PROFIT Project's Employer-based Initiative was that the Project gave Hwange Colliery, one of the 10 companies that participated in the Initiative, a grant to bring in ZNFPC trainers to train their staff on-site instead of sending them to the ZNFPC as was the custom. A four week on-site family planning course was conducted for 11 nurses and the practicals were done in the company clinics where they worked. Thus, these nurses would be well-equipped to deal with the constraints of their work-site in providing family planning services.

Additionally, as PROFIT worked with the private providers two obstacles related to medical aid were identified, and the Project attempted to address them while working on its other objectives.

MEDICAL AID INITIATIVE

Although it wasn't a project objective per se,

The first issue was the limited amount of medical aid coverage available for family planning services and supplies. Thus, although not an objective per se, PROFIT successfully persuaded the two main Medical Aid Societies, the Public Sector Medical Aid Society (PSMAS) and the Commercial and Industrial Medical Aid

PROFIT succeeded in persuading the two largest medical aid societies (health insurance) to increase the annual amount of coverage for family planning an average of 45 percent.

Society (CIMAS) to increase their yearly allocation for family planning supplies and services. They increased their annual amounts 60 and 30 percent, respectively.

The other issue is that the tariffs are limited under medical aid for family planning and results in discouraging doctors, or even pharmacists, and eventually nurse-midwives to recover costs for the services they provide. This restriction has resulted in practitioners categorizing family planning services under other codes such as "general consultation". Until the tariffs are sorted out, family planning service provision in the private sector will be constrained and their utilization difficult to tract.

The PROFIT Project attempted to deal with the tariff issue by bringing together Obstetricians and Gynecologists to outline a list of tariffs for family planning services. At the request of the National Association of Medical Aid Societies(NAMAS), the proposal for the family planning tariffs will be presented to NAMAS by the Association of Obstetricians and Gynecologists. By the end of the PROFIT Project, no agreement has been reached.

Although addressing these two issues provided beneficial, the only stated objective for the Project's work with the medical aid societies was not accomplished. This objective was to assist them in notifying their beneficiaries of the coverage for family planning and encouraging them to use such coverage. It was anticipated that as part of the consumer campaign, a brochure would be developed that CIMAS and PSMAS would send to their clients. However, neither of these societies provided the necessary information for such a brochure. It seemed they were unwilling to commit to print what services or amounts would included as coverage.

CONSUMER INITIATIVE

The consumer education campaign was planned to inform and motivate consumers to seek family planning commodities and services from private sector practitioners. However, there were several delays that taken together prevented the launch. With USAIDs agreement, the PROFIT Project turnover the tasks associated with the consumer education campaign and Population Services International (PSI) who would assume the responsibilities for private sector activities after the close out of the PROFIT Project at the end of September 1997.

COMMODITIES INITIATIVE

Despite the delays in getting contraceptive commodities, the initiative was successful in having reduced import duties by 50 percent.

The Commodities Initiative, which was supported by USAID and ZNFPC, was successful in identifying a company interested in taking steps to import and sell appropriately priced products for the private sector providers. Additionally, it was instrumental in having the import duties for contraceptive commodities reduced 50 percent: from 10 percent to five.

To address the need for available and appropriately priced product, the PROFIT Project organized a workshop in November 1996 that brought together key players in the public and private sectors to discuss the issues and problems related to commodities and outline recommendations of what needed to be done to overcome these problems. Subsequent to these discussions and acting on their recommendations, the PROFIT Project was able to interest pharmaceutical companies, Wyeth and Schering, which are manufacturing companies, and PROCARE, Inc., a local distributing company, to bring in oral contraceptives for the private sector at a reasonable price. As a result, Wyeth and Schering applied to the Medicines Control Authority (MCA) (previously known as the Drugs Control Committee or DCC) to register two oral contraceptives, Duofen (which has the same composition as the public sector Lo-Femenol) and Microgynon, respectively. These applications, however, are still pending. PROCARE, Inc. which already had registered Microlut, a progestin only pill manufactured by

Schering, pledges to bring this commodity in and make it available at an affordable Z$7.50 (approximately US$0.70) to the end user. It also promised to bring in NORPLANT, which would be sold directly to the pharmacists and general practitioners. Due to delays, however, these commodities have not made their way into the market. "The Commodities Initiative didn't meet with the success that we would have liked, but this was not for a lack of trying." said Girlie Madyara, member of the PROFIT Project Coordinating Committee, and Operations Director at Geddes Pharmaceutical Company in Zimbabwe. As Dr. Zinanga, the Executive Director of the Zimbabwe National Family Planning Council (ZNFPC) pointed out, "The success of [this component of] the Project depended on other sectors...(like the MCA)...and the time was too short..." Nonetheless, it would be ideal if the private sector had an independent source of contraceptive supplies and didn't have to depend on the public sector.

The PROFIT Project also approached MCA with two other proposals: (1) authorization for private general practitioners to dispense oral contraceptives; and (2) authorization for nurses at the "model" pharmacies to provide injectables on-site. Both these proposals were turned down. The first was rejected on the grounds that general practitioners without dispensing licenses could not dispense oral contraceptives, despite arguments that these doctors be issued licenses that limited their dispensing powers to oral contraceptives. [It should be noted that ZNFPC's community-based distributors (CBDs) are non-medical personnel and are initiating and distributing oral contraceptives.] MCA rejected the second proposal on the grounds that there would be no way to ensure that no other drugs would be injected at the pharmacies. This decision, particularly, is difficult for the "model" pharmacies as women cannot understand why they have to go back to their GPs when the nurses at the pharmacies are qualified to give them injections. Yet, despite the stumbling blocks which were really beyond the control of the Project, Ms. Madyara feels that a lot was accomplished in the pursuit of increasing family planning service provision in Zimbabwe's private sector.

In Conclusion

The Project clearly achieved a great deal in a short time. Private doctors, retail pharmacists, industrial nurses and private nurse midwives were trained in family planning. In addition, company-based peer educators were oriented in male motivation techniques. But the extent to which this training has translated into actual family planning service provision in the private sector is unknown. Given the short life span of this Project a comprehensive evaluation has not been possible and besides, it is unlikely that the impact will be evident in such a short time. "We hope to see the impact, that is the move to private sector services, in the next DHS? the 1998 DHS," said Roxana Rogers of USAID Harare. "This Project is the first step in a process that is going to have a long-term impact. Even though a shift towards the use of private sector family planning services was already taking place, this Project has ensured that the practitioners are adequately trained. Moreover, there is anecdotal evidence which suggests that those who have been trained are offering family planning services as a result of their newly acquired or expanded knowledge and skills", she said.

The Project Design: Unlike earlier USAID funded projects which focused on one particular aspect of the private sector in Zimbabwe, the PROFIT Project has been a comprehensive attempt to involve and mobilize all players who have the potential to expand family planning services in the private sector. This was a comprehensive project that tried to involve all sectors that have the potential of contributing to the expansion of family planning services in the private sector.

"As we saw it,it was a Project that was exploring the unexplored ground," said Girlie Madyara. Even though the life span of the Project was too short to effectively deal with policy constraints, a lot in terms of training, was accomplished. As Roxana Rogers of USAID said, "it was a question of doing something about what we can do or waiting until there were changes in policy." The choice to do something about what can be done, with the hope that this in itself would be a catalyst for policy change was probably a good one as the momentum in the expansion of family planning services in the private sector is becoming evident.

The Potential for Sustainability: Another important aspect of this private sector subproject which is realted to the project design is that it has the very real potential for being sustainable. Quoting Professor Kasule, "the particular advantage of the training provided by the Project, is that it trained private sector doctors, who are a 'permanent sector' and are unlikely to move. Unlike trained public sector doctors who are more likely to go to Botswana or South Africa in search of greener pastures and be lost to the [Zimbabwe] system. Once family planning services are a part of the private sector system, they will be a part of the system forever." "They will be part of the system as long as we have private medicine in this country," reiterated MacDonald Chaora from NAMAS.

The Dialogue between the Private and Public Sectors: Even though the Project was coordinated independently, it fostered close ties with ZNFPC, which has the mandate for and resources to coordinate family planning in this country. This collaboration has given the ZNFPC leadership the opportunity to have input into the Project's implementation and that fostered the feeling that it is part of ZNFPC's overall effort to expand family planning services in this country. In turn, the Project was able to benefit from ZNFPC's regionally renowned training capacity, which was used to train nurse midwives for several of the Project's initiatives: the private nurse midwives, work-site-based nurses and peer educators, and the pharmacy staff for the "model" pharmacies. ZNFPC's involvement in the training gave the Project credibility, because ZNFPC has the mandate and expertise in Zimbabwe. Moreover, because the ZNFPC leadership was involved at a variety of levels, they were willing to provide temporary support and make contraceptive commodities available to the private sector while other mechanisms are being put into place. commodities for the private sector, ZNFPC agreed to step in and fill the gap as was necessary.

The Independent Co-ordination: Even though the close collaboration with the public sector was an important factor in the Project's success, its independence gave it the flexibility to move quickly. As one of the doctors pointed out, a training workshop in the public sector often took three to four months to organize. Yet this Project was able to organize them in a matter of weeks. In fact, all the training workshops for doctors were completed in a three to four month period. The independence of this project also helped various groups to come together to work as a team, keeping in mind the common goal of expanding contraceptive services in the private sector. The Project created a momentum and showed what professional associations can accomplish and gave them the mandate to assume the responsibility for continuing family planning education.

The PROFIT Project? s Emphasis on the Participatory Approach: By involving the beneficiaries in the planning and implementation of the Project, through the establishment of the Steering Committee and Working Groups, the Project has belonged to all those who have been involved. ? The Project involved the stakeholders in a very positive way. In fact if it were to be continued it would be much easier to sustain it.? Said Dr. Zinanga.

The Professionalism and Enthusiasm of the PROFIT Project Staff: The professionalism and enthusiasm of the PROFIT staff have been highly commended by all those who were a part of the Project. They have worked tirelessly to ensure the success of the project because they were truly committed to its success. ?From the word go, they believed in action? said Dr. Kasule. "Honestly, I take my off my hat to the PROFIT staff..." said Girlie Madyara...I know it was Lois' (Lunga, Project Director) job but she went beyond her call of duty!"

The Local Co-ordination:"This is the first USAID Project in Zimbabwe that is managed by Zimbabweans.", said Roxana Rogers, who felt that this was one of the main reasons for the response it got. "The fact that the managers of the Project have been Zimbabwean has been an advantage," said Mr. Andrew Vaughn. The main coordinator was ZNFPC's private sector program coordinator for many years and was familiar with the system. The PROFIT what needed to be done, whom to contact and whose help to enlist. Moreover, ".... it dispelled any question of hidden agendas...", said Dr. Mamsa. "The involvement of the PROFIT staff in the next phase would definitely help with continuity," said Girlie Madyara.

The PROFIT Project was successful because of a combination of factors. It developed a comprehensive set of initiatives; it used a participatory approach for design, implementation, and evaluation; and its staff were competent and dedicated; Finally, it was able to forge successful partnerships to accomplish its goals and make strides toward sustainability of the efforts begun under this project.